

#### DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317 To Report Adult Abuse: (800) 564-1612 Fax (802) 871-3318

July 6, 2012

Ms. Ursula Margazano, Administrator Burlington Health & Rehab 300 Pearl Street Burlington, VT 05401

Provider #: 475014

Dear Ms. Margazano:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **June 5, 2012**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS

amlaMCHaRN

Licensing Chief

PC:ne

**Enclosure** 



JUN 29 2012

PRINTED: 06/15/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONST	(X3) DATE SURVEY COMPLETED		
		475014	B. WIN				C <b>)5/2012</b>	
	PROVIDER OR SUPPLIER  GTON HEALTH & RE	HAB  ATEMENT OF DEFICIENCIES	ID	3	00 PEARL BURLINGT	ON, VT 05401		T
PREFIX TAG	(0.4.0)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 000	INITIAL COMMEN		F (	000		The following constit	tutes the	
F 281 SS=D	was conducted by Protection on May June 5, 2012. The related to the com 483.20(k)(3)(i) SEI PROFESSIONAL	RVICES PROVIDED MEET STANDARDS	F2	281		facility's response to findings of the Depar Licensing and Protect does not constitute a admission of guilt or agreement of the facilleged or conclusion forth on the summary	the tment of ction and in ts	
	must meet profess	ded or arranged by the facility ional standards of quality.  NT is not met as evidenced			<u>F-281</u>	The facility maintains t monitors changes in reclinical status.	hat it	
	Based on complai and record review, facility did not mee quality for 1 reside failing to monitor a	nant interview, staff interviews the services provided by the t professional standards of nt in the sample regarding change in the resident's sident #1) Findings include:				How the corrective ac will be accomplished those residents found affected by the allege deficient practice?: Education to the nurse	for d to be ed	
	to assess and /or r #1's clinical status from the licensed r	on 5/2/12, the staff nurse failed nonitor a change in Resident after s/he received a report nursing assistant (LNA) that the g an 'anxiety attack.' Per				- monitor all residents to a change in clinical sta DON, ADON, SDC, &/o designee	tus. <b>or</b>	6-27-12
	record review, on 4 P.M. the LNA repo Resident #1's daug mother was having reported this to the	l/15/12 at approximately 7:30 rted to the staff nurse that phter reported to her that her an 'anxiety attack.' The LNA nurse who was in the process ange of shift report' from the				How will the facility ic other residents havin potential to be affects same deficient practic All residents are potent affected by this alleged	g the ed by the ce?:	
-	day nurse. The nur the vital signs for F vital signs and reportesident's pulse was saturation (02 sat)	Resident #1. The LNA to obtain Resident #1. The LNA took the orted back to the nurse that the as 131 and the oxygen was 60% (while on 4 liters of				deficient practice.		On-going
ABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	70	minu	trator lel	26/18	(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: MGR211

Facility ID: 475014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
,		475014	B. WING			С		
				Τ		06/0	05/2012	
NAME OF PROVIDER OR SUPPLIER  BURLINGTON HEALTH & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE  300 PEARL STREET  BURLINGTON, VT 05401				
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F 281	having chest pain/d The nurse went to treported that the reat her to 'call 911!' 4/15/12 at 20:45, the reassessed the resethe oxygen saturated documented in the elevated the head of (nebulizer) treatments supervisor trying to calling the MD.' What to reach the on-call daughter called 911 within minutes and documented on the upon arrival, the pain, was sitting up neb (nebulizer) at 6 minute) not moving breath. The 02 satures (DNS) on confirmed that s/he 60% to be reported S/he also confirmed educated after the family knows the refamily felt that	and that the resident was ifficulty breathing.  he resident's room and sident's daughter was yelling Per nursing documentation on ere was no evidence that s/he ident's vital signs, including	F	281	What measures will be into place or systems changes made to ensithe deficient practice recur?: Education to nurses - monitor all research who have a change in estatus.  DON, ADON, SDC, &/odesignee  How will the facility not recurse that the deficity practice will not recurse for residents with a characteristical status X 4 weeks through clinical stand-underling (concurrent revinsure change is monitor Results reported at Action Team and QA meetings changes made as appropriate that the deficity practice will not recurse the practice will not	atic sure that will not all sidents clinical or nonitor to ent r?: per unit nge in s p view) to ored. on with	7-2-12	

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	Continued From page 2 Resident #1's 'anxiety attack.' S/he also confirmed that s/he had not taken the pulse or checked the resident's oxygen saturation rate after the LNA reported an 02 sat of 60%. S/he also confirmed that s/he had not called 911 because s/he was waiting to speak with the physician to receive 'transfer orders first.'  Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.		F 309	The facility maintains to provides the necessar and services to attain maintain the highest polysical, mental, and psychosocial well-bein accordance with the comprehensive assess and plan of care.  How the corrective awill be accomplished those residents foun affected by the allege deficient practice?: Education to the nurse immediately evaluate resident that has a chackinical status, evidence time documentation.  DON, ADON, SDC, & designee	y care or racticable  ng, in sment  ction(s) I for d to be ed e involved e any ange in ced by
	by: Based on complair and record review, one resident (Resid and services to mai physical, mental an regarding seeking p resident in acute dis  Per record review of to assess and /or m #1's clinical status a from the licensed n	NT is not met as evidenced nant interview, staff interviews the facility failed to provide lent # 1) the necessary care intain the highest practicable d psychosocial well-being prompt medical attention for a stress. Findings include:  on 5/2/12, the staff nurse failed nonitor a change in Resident after s/he received a report ursing assistant (LNA) that the g an 'anxiety attack.' Per		How will the facility in other residents having potential to be affected same deficient practice.  All residents are potent affected by this alleged deficient practice.	ng the ed by the lice?:

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F 309	record review, on 4 P.M. the LNA repor Resident #1's daug mother was having reported this to the of receiving the 'chi day nurse. The nur the vital signs for R vital signs and reported that signs are resident's pulse was aturation (02 sat) continuous oxygen having chest pain/of.  The nurse went to reported that the reat her to 'call 911!' 4/15/12 at 20:45, threassessed the residented in the elevated the head of (nebulizer) treatme supervisor trying to calling the MD.' With to reach the on-call daughter called 91' within minutes and documented on the upon arrival, the pain, was sitting up neb (nebulizer) at 6 minute) not moving breath. The 02 satures and the control of the pain, was sitting up neb (nebulizer) at 6 minute) not moving breath. The 02 satures are recorded to the control of the pain, was sitting up neb (nebulizer) at 6 minute) not moving breath. The 02 satures are recorded to the pain, was sitting up neb (nebulizer) at 6 minute) and the pain, was sitting up neb (nebulizer) at 6 minute) not moving breath. The 02 satures are recorded to the pain was sitting up neb (nebulizer) at 6 minute) and the pain was sitting up neb (nebulizer) at 6 minute) and the pain was sitting up neb (nebulizer) at 6 minute) and the pain was sitting up neb (nebulizer) at 6 minute) and the pain was sitting up neb (nebulizer) at 6 minute) and the pain was sitting up neb (nebulizer) at 6 minute) and the pain was sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a sitting up neb (nebulizer) at 6 minute was a	/15/12 at approximately 7:30 ted to the staff nurse that ther reported to her that her an 'anxiety attack.' The LNA nurse who was in the process ange of shift report' from the se instructed the LNA to obtain tesident #1. The LNA took the orted back to the nurse that the staff and the oxygen was 60% (while on 4 liters of ) and that the resident was difficulty breathing.  The resident's room and resident's daughter was yelling Per nursing documentation on there was no evidence that s/he ident's vital signs, including on rate. The nurse progress notes that s/he of the bed, gave a neb int and 'notified (the) stabilize (the) resident before hile the nurse was attempting physician, the resident's if the ambulance arrived the ambulance personnel her pre-hospital care report that attent complained of chest in bed with 0.5 albuterol by SL/M (oxygen at 6 liters per any air and gasping for uration rate was 55%.  The Director of Nursing	F	309	What measures will k into place or systems changes made to ens the deficient practice recur?: Education to nurses - Immediately e any resident that has a in clinical status, evide time documentation. DON, ADON, SDC, &/ designee  How will the facility in its corrective actions ensure that the defici practice will not recu 5 random audits/week of residents with a cha clinical status X 4 wee through clinical stand- meeting (concurrent re insure that immediate evaluation of a residen change in clinical statu performed, as evidence time documentation. F reported at Action Tea QA meetings with chan made as appropriate. DON, ADON, SDC, &/ designee  F309 POC accepted 71512  DCWITTENDURY DEVIATION.	atic sure that will not all evaluate a change anced by for nonitor sto ient re: per unit ange in ks up eview), to at with a us is ed by Results m and nges	7-2-12	
		5/2/12 at 12:30 P.M. s/he would 'expect an 02 sat of						

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F 309	S/he also confirmed educated after the family knows the refamily felt that the refamily felt that the refamily felt that the reference room) to the hospital-call that made. Per intervie 5/2/12 at 1:00 P.M. spent between 10 a change of shift report that s/he confirmed that s/he checked the reside after the LNA report also confirmed that because s/he was the side of	ge 4 to the physician immediately.' d that the staff nurse was facility investigation that 'the sident more than we do and if esident should go to the ER to call 911 and get the resident the doctor after the 911 call is the with the staff nurse on she confirmed that she had and 20 minutes more in out after the LNA reported the ty attack.' She also had not taken the pulse or out's oxygen saturation rate ted an 02 sat of 60%. She she had not called 911 waiting to speak with the tel transfer orders first.'	F	309			
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